VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

January 18, 2012

Mr. Andre Courcelle, Administrator
7 Royce Street
7 Royce Street
Rutland, VT 05701

Provider #: 0503

Dear Mr. Courcelle:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 1, 2011.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS
Licensing Chief

PC:ne

Enclosure

PRINTED: 11/08/2011
FORM APPROVED

Division of Licensing and Protection

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0503 | A. BUILDING _____ B. WING _____ | 11/01/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 7 ROYCE STREET | 7 ROYCE STREET RUTLAND, VT 05701 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| T 001 | INITIAL COMMENTS<br><br>An unannounced onsite re-licensure survey was conducted by the Division of Licensing and Protection on 11/1/2011 to determine compliance with the Therapeutic Community Residences Licensing Regulations. | T 001 | See attached Plan of Correction (POC) | |
| T 003 | IV.A.2 Resident Care and Supervision<br><br>Medication<br><br>The Director shall assure that all medications and drugs are:<br>a. used only as prescribed by the resident's physician<br>b. properly labeled and kept in a locked cabinet at all times or, when a program of self-medication is in effect, otherwise safely secured.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the Director failed to assure appropriate storage and transcription / clarification of medications for 2 applicable residents in the survey sample (Resident #1 and Resident #3). Findings include:<br><br>1. Per observation on 11/1/11 from 11:25 AM to 11:40 AM, the medication cabinet was left unlocked and out of the visual range of the staff member administering medications. During interview that afternoon, the staff member confirmed that the medicine cabinet was left unlocked during this period of time and that it should always be locked.<br><br>2. Per record review on 11/1/11, there was a discrepancy between the most recent physician medication orders and the MAR (Medication | T 003 | | |

Division of Licensing and Protection Andre' R Councelle TITLE 11/28/11 (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Director of Residential & Community Supports



PMC

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| T 001 | INITIAL COMMENTS<br><br>An unannounced onsite re-licensure survey was conducted by the Division of Licensing and Protection on 11/1/2011 to determine compliance with the Therapeutic Community Residences Licensing Regulations. | T 001 | | |
| T 003 | IV.A.2 Resident Care and Supervision<br><br>Medication<br><br>The Director shall assure that all medications and drugs are:<br>a. used only as prescribed by the resident's physician<br>b. properly labeled and kept in a locked cabinet at all times or, when a program of self-medication is in effect, otherwise safely secured.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the Director failed to assure appropriate storage and transcription / clarification of medications for 2 applicable residents in the survey sample (Resident #1 and Resident #3). Findings include:<br><br>1. Per observation on 11/1/11 from 11:25 AM to 11:40 AM, the medication cabinet was left unlocked and out of the visual range of the staff member administering medications. During interview that afternoon, the staff member confirmed that the medicine cabinet was left unlocked during this period of time and that it should always be locked.<br><br>2. Per record review on 11/1/11, there was a discrepancy between the most recent physician medication orders and the MAR (Medication | T 003 | | |

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| T 003 | Continued From page 1<br>Administration Record) for Resident #1. The MAR indicated orders for 'Lisinopril 2.5 mg (milligram) Q (every) 8 AM', 'Metformin 500 mg Q AM & 1000 mg Q 5 PM', 'Calcium w/ vitamin D 500 mg 8 AM & 5 PM', and 'Glipizide CXL 2.5 mg at 5 PM'. Review of the current and prior month MAR indicated the Resident received these medications regularly. There were no physician orders for these medications in the resident record. During interview that afternoon, the Supervisor confirmed that there was a discrepancy between the MAR and the physician orders, that the resident regularly receives these medications, and that no clarification of this discrepancy had been sought from prescribing physician.<br><br>3. Per record review on 11/1/11, there was a discrepancy between the most recent physician medication orders and the MAR (Medication Administration Record) for Resident #3. Physician orders indicated: 'Acetaminophen 500 mg PRN (as needed)', 'Calcium 500 mg 2 tabs in AM', 'Gas-X Extra strength 125 mg PRN', 'Loperamide HCL (2 mg cap) 4 X qd', 'Niacin CR (500 mg tab) 1 tab every PM and take 325 mg of aspirin 1 hour prior to dose'. Review of the MAR for this resident for the prior and current month indicated the resident receives 'Tylenol 1000 mg w/ Nexium 40 mg at 8 AM & 4 PM', 'Calcium with vitamin D 500 mg 2 tabs at 8 AM', 'Gas-X --1 after breakfast, lunch, supper', 'Loperamide HCL 2 mg after lunch', and no order for 'Niacin CR (500 mg) every PM and '325 mg Aspirin 1 hour prior to [sic Niacin] dose'. During interview that afternoon, the Supervisor confirmed that the MAR and physician orders for these medications are conflicting and that the resident is receiving medications for which the record contains no written physician orders. | T 003 | | |

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| T 003 | Continued From page 2<br><br>4. Per record review, there were 3 circumstances indicated under which Resident #3 should receive Gas-X: before meals, after meals and at any time. There was no clarification regarding the timing of administration of this medication. Per observation at 11:25 AM, Res #3 received Gas X with lunch rather than after lunch as indicated by MAR and pharmacy label. During interview that afternoon, the Supervisor confirmed that the timing of the administration of this medication was unclear and that clarification should be obtained. | T 003 | | |
| T 009 | IV.B.1 Physical Environment<br><br>General<br>a. The residence must meet all appropriate provisions of local building codes and zoning ordinances and regulations of the Vermont State Fire Code.<br>b. The residence shall provide a comfortable, sanitary and safe environment for residents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the Director failed to assure a safe environment for residents. Findings include:<br><br>1. Per observation during initial environmental tour with a staff member, the laundry products cabinet on the second floor was unlocked. The cabinet was clearly marked to indicate it should be locked. The staff member confirmed that the cabinet was unlocked and that it should be locked.<br><br>2. Per observation throughout the morning hours, | T 009 | | |

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| T 009 | Continued From page 3<br>a container of Chlorine water purifier tablets were on the window sill above the resident accessible kitchen sink. During interview following lunch, a staff member confirmed that the tablets were improperly stored. | T 009 | | |
| T 031 | IV.B.3.f. Physical Environment<br><br>Sanitation:<br><br>The residence shall meet health and sanitation regulations of the Vermont Department of Health.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the residence failed to meet health and sanitation regulations of the Vermont Department of Health regarding food preparation / handling. Findings include:<br><br>1. Per observation of the noon meal preparation on 11/1/11, a staff member ceased meal preparation to record information in the record of Resident #1. There was no hand washing prior to resuming preparation of sandwiches. The staff member also did not cleanse hands after two observations of touching trash can lid during disposal of trash with bare hands and prior to returning to preparation of the lunch meal. During interview at 12:30 PM, the staff member confirmed that she / he had not implemented proper hand hygiene during the meal preparation.<br><br>Reference: Safe food handling retrieved 11/7/11 from the Vermont Department of Health website at:<http://healthvermont.gov/enviro/food_lodge/food_safety.aspx> | T 031 | | |

Community Access Program

P.O. Box 222, 78 South Main Street, Rutland, Vermont 05702 o (802) 775-0828 o Fax: (802) 747-7692
Information & Referral: (802) 747-7696 or Toll-free 877-430-2273 o TTY/TDD: 800-253-0191

November 14, 2011

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306

RE: Plan of Correction for 7 Royce Street

On November 1, 2011 the re-licensing survey revealed deficiencies at the Royce Street Therapeutic Community Residence (TCR). The following is our plan of correction for the deficient practices identified in the survey.

IV.A.2 Resident Care and Supervision

Medication: 1) The medication cabinet will be locked at all times and the consulting nurse will provide ongoing training at staff meetings to all staff regarding the TCR regulations and best practices for handling and administering medications.

2-3) The Medication Administration Record (MAR) will match the physicians orders for all the individuals residing at the TCR. The consulting nurse has reviewed the records and is in the process of obtaining accurate physician's orders for all the residents. A physician's medication review list is being developed to ensure that all the physicians are in agreement with the current medication regime for each of the people under their care. The residential supervisor, Case Manager and the Consulting Nurse will ensure that all changes in medication are reflected in the physician's orders and the MAR. The Residential Director will review this process quarterly to ensure the procedure is being followed.

4) The consulting nurse and case manager will obtain clarification on the timing of this medication and all medications for all the people residing at the TCR. The residential supervisor will contact the consulting nurse after doctor appointments, med checks or any other time an individual's medications may have changed.

Per a phone call with the Director of Residential and Community Support, the Completion Date is: 11/22/11

POC accepted 1/12/12 RNcotaRN

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IV.B.1 Physical Environment

General: 1-2) The residential supervisor will re-train the staff on the procedures for the proper storage and handling of all chemicals being used in the house. The residential supervisor will monitor on a daily basis during regular shifts as well as spot checks on all other shifts to ensure that all staff is compliant with established best practices for storing and handling chemicals.

Completion Date: 11/8/11
POC accepted 1/12/12 BMcLaRN

IV.B.3.f Physical Environment

Sanitation: 1) The residential supervisor will review the referenced Safe food handling information from the Vermont Department of Health website along with any other related information recommended by the consulting nurse. The consulting nurse and the residential supervisor will train all staff in safe food handling and best practices for meal preparation. The residential supervisor will conduct intermittent checks to ensure that safe food handling is maintained.

Completion Date: 11/8/11
POC accepted 1/12/12 BMcLaRN

All the deficiencies will be covered with all staff and systems will be put in place to ensure best practices are used moving forward. The team will use this learning opportunity to improve the quality of services we provide to the individuals residing at Royce Street. If you have any questions please contact me at 802-786-7302

Sincerely,

Andre' R Courcelle

Andre R Courcelle
Director of Residential & Community Supports
Community Access Program
78 South Main Street
Rutland VT 05701